North Carolina Department of Health and Human Services
2001 Mail Service Center • Raleigh, North Carolina 27699-2001
Tel 919-733-4534 • Fax 919-715-4645 • Courier 56-20-00
Michael F. Easley, Governor Carmen Hooker Odom, Secretary

October 1, 2003

The Honorable Steve Metcalf, Co-Chair
Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities
and Substance Abuse Services
Legislative Office Building, Room 520
300 N. Salisbury Street
Raleigh, North Carolina 27603

Dear Senator Metcalf:

I am pleased to submit to you and to the other members of the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services our report of **deaths** for SFY 2002-03 **for facilities that are not licensed** in accordance with G.S. 122C, Article 2 or are not state facilities operating in accordance with G.S. 122C, Article 4, Part 5. I hope you will find it helpful and informative.

Sections 3(b), 5(b) and 6(b) of House Bill 1520, Session Law 2000-129, and Sections 1-4 of House Bill 80, Session Law 2003-58, require the Department to submit to the Commission an annual report of the number of deaths reported under GS 122C-31. A report of the number of deaths for licensed facilities, state facilities, and inpatient facilities will be submitted separately.

If you have any questions about the enclosed report, please feel free to contact Rich Visingardi, Flo Stein or Spencer Clark at the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services at (919) 733-7011.

Sincerely,

Original Signed

Carmen Hooker Odom

CHO:mss

Enclosure

cc: Lanier Cansler
Jim Bernstein
Daphne Lyon
Allyn Guffey
Bob Fitzgerald
Susan Morgan
Legislative Libraries (2)
DMH/DD/SAS Executive Leadership Team

North Carolina Department of Health and Human Services
2001 Mail Service Center • Raleigh, North Carolina 27699-2001
Tel 919-733-4534 • Fax 919-715-4645 • Courier 56-20-00
Michael F. Easley, Governor Carmen Hooker Odom, Secretary

October 1, 2003

The Honorable Verla Insko, Co-Chair
Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities
and Substance Abuse Services
Legislative Building, Room 1323
16 West Jones Street
Raleigh, North Carolina 27603

Dear Representative Insko:

I am pleased to submit to you and to the other members of the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services our report of **deaths** for SFY 2002-03 **for facilities that are not licensed** in accordance with G.S. 122C, Article 2 or are not state facilities operating in accordance with G.S. 122C, Article 4, Part 5. I hope you will find it helpful and informative.

Sections 3(b), 5(b) and 6(b) of House Bill 1520, Session Law 2000-129, and Sections 1-4 of House Bill 80, Session Law 2003-58, require the Department to submit to the Commission an annual report of the number of deaths reported under GS 122C-31. A report of the number of deaths for licensed facilities, state facilities, and inpatient facilities will be submitted separately.

If you have any questions about the enclosed report, please feel free to contact Rich Visingardi, Flo Stein or Spencer Clark at the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services at (919) 733-7011.

Sincerely,

Original Signed

Carmen Hooker Odom

CHO:mss

Enclosure

cc: Lanier Cansler
Jim Bernstein
Daphne Lyon
Allyn Guffey
Bob Fitzgerald
Susan Morgan
Legislative Libraries (2)
DMH/DD/SAS Executive Leadership Team

bcc: Bonnie Allred
Aleta Mills
Joe Slaton
John Tanner, DSS
Pam Richardson, OSBM
Jeff Horton, DFS
Jim Upchurch, DFS
Jackie Sheppard, DFS
Mark Benton, DFS
Doug Barrick, DFS
Spencer Clark, DMH/DD/SAS
Mike Schwartz, DMH/DD/SAS
Peggy Balak, DMH/DD/SAS

Report to

JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES

on

Deaths Reported By Facilities Not Licensed In Accordance With G.S. 122C, Article 2 And Not State Facilities Operating In Accordance With G.S. 122C, Article 4, Part 5

as originally required by SL 2000-129, Section 3(b), 5(b) and 6(b)
and as amended by SL 2003-58, Sections 1-4

Submitted by
Division of Mental Health, Developmental Disabilities, and Substance Abuse Services
Department of Health and Human Services

September 2003

INTRODUCTION

Section 3(b), 5(b) and 6(b) of Session Law 2000-129 (HB 1520), as amended by Sections 1-4 of Session Law 2003-58 (HB 80), requires the Department of Health and Human Services to report annually to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services on the number of deaths reported in certain facilities.

10A NCAC 26C .0300 et. al. implement the death reporting requirements of these laws and provide specific instructions to facilities for reporting deaths.

- **Facilities not licensed** in accordance with G.S. 122C, Article 2 and not state facilities operating in accordance with G.S. 122C Article 4, Part 5 shall report client deaths to the **Division of Mental Health, Developmental Disabilities, and Substance Abuse Services**.
- **Facilities licensed** in accordance with G.S. 122C, Article 2, **state facilities** operating in accordance with G.S. 122C Article 4, Part 5 and **inpatient psychiatric units** of hospitals licensed under G.S. 131E shall report client deaths to the **Division of Facility Services**.

This report provides a compilation of data for deaths reported during the period July 1, 2002 to June 30, 2003[1] to the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services by facilities not licensed in accordance with G.S. 122C, Article 2 or not state facilities operating in accordance with G.S. 122C Article 4, Part 5. The Division of Facility Services shall provide a separate report for deaths that were reported to it by licensed facilities, state facilities, and inpatient psychiatric units.

Blank copies of the death reports used by facilities are included as Attachment A and can be found at the end of this report.

DEATHS REPORTED

Session Law 2000-129 amended G.S. 122C-31, 131D-10.6B and 131D-34.1 by requiring certain facilities to notify the Department of Health and Human Services of any death:

- Occurring within 7 days of use of physical restraint or physical hold of a resident; or
- Resulting from violence, accident, suicide or homicide.

The following chart depicts each facility that reported one or more deaths for the time period beginning July 1, 2002 and ending June 30, 2003. Each chart identifies the number of deaths reported, the number of deaths that occurred within 7 days of restraint or seclusion, and the number of those deaths that were found to be the result of the

[1] The effective date of House Bill 1520 was January 1, 2001, and the effective date of House Bill 80 was May 20, 2003.

facility's use of physical restraint or seclusion. If a facility is not listed, a death was not reported to the Department.

Facilities not licensed in accordance with G.S. 122C, Article 2 and not state facilities operating in accordance with G.S. 122C Article 4, Part 5:

Reporting Facility	# Deaths Reported	# Deaths within 7 days of Restraint/ Seclusion	# Deaths due to Restraint/Seclusion
Alamance-Caswell Area MH/DD/SAS	8		
Albemarle Mental Health Center	3		
Alcohol and Drug Services of Guilford County	1		
Blue Ridge Center	2		
CenterPoint Human Services	1		
Crossroads Behavioral Resthome	1		
Cumberland County Mental Health Center	3		
Davidson County MH/DD/SAS	2		
Developmental Disabilities Resources (Charlotte)	2		
Durham Center	6	1	0
Edgecomb-Nash Mental Health Center	1		
Foothills Area MH/DD/SAS	4		
Mecklenburg County Area Mental Health	3		
Moses Cone Hospital (Greensboro)	1		
New River Behavioral Healthcare	2		
Onslow County Behavioral Healthcare Services	6		
Pathways Area MH/DD/SAS	2		
Pee Dee Apartments (Albemarle)	1		
Piedmont Behavioral Healthcare	5		
Pitt County MH/DD/SAS	1		
Randolph County MH/DD/SAS	8		
RiverStone Counseling & Personal Development	2		
Rockingham County MH/DD/SAS	1		
Smoky Mountain Center	15		
Southeastern Regional Area MH/DD/SAS	6		
Suttons Rest Home (Goldsboro)	1	1	0
Teccare Durham ACTT	1		
Wake County Human Services	9		
Total	**98**	**2**	**0**

NOTE: Shading in the last two columns indicate that there were no reported Deaths within 7 days of Restraint or Seclusion.

Many facilities voluntarily reported deaths that were not subject to G.S. 122C-31. For example, 35 of the 98 reported deaths were for medical reasons, and did not occur within 7 days of restraint/seclusion, and were not the result of violence, accident, suicide, or homicide. These deaths were not required to be reported. All deaths that were reported were logged in the Division's database and were included in the above chart.

During the period of this report, two deaths that were reported occurred within 7 days of restraint/seclusion. Neither of the deaths was the result of restraint or seclusion. In the Durham Center case, deficiencies were noted by the Division of Facility Services (DFS) involving the use of restraints and failure of the facility to protect the patient from

harm. In addition to being reported by the Durham Center, the death was reported to DFS by John Umstead Hospital where the client was an inpatient at the time. Corrective actions were implemented as a result of DFS's investigation.

REPORT OF DEATH TO DHHS

All requested information must be provided. This form is for reporting deaths for all facilities operating under G.S. 122C and psychiatric units of hospitals licensed under G.S. 131E. All deaths related to use of seclusion or restraint, accidents, homicides, suicides or violence must be reported. If any requested information is unavailable, provide an explanation. The information must be provided immediately upon its availability. ■ *If additional space is needed*, attach separate sheets, referencing the part of the form to which the information pertains. ■ You may include additional information that you consider helpful, such as client assessments and discharge summaries. ■ **(Please Note: Facilities are encouraged to keep a copy of the report for their records)**

***Send or fax form to*: Licensed facilities - Chief, Mental Health Licensure & Certification Section, Division of Facility Services, 2718 Mail Service Center, Raleigh, NC 27699-2718. Fax: (919) 715-8077; Phone: (919) 715-8076.**
Unlicensed facilities – Chief, Program Accountability Section, DMH/DD/SAS, 3012 Mail Service Center, Raleigh, NC 27699. Fax: (919) 881-2451; Phone (919) 881-2446.

Section I: Reporting Facility

Name of reporting facility:	Medicare/Medicaid Provider # (if applicable):	Facility director:	Telephone:
Address:	License # (if applicable):	First person to discover decedent:	Staff first receiving report of decedent's death:
	County:	Person (including title) preparing report:	Date/Time report prepared:

Section 2: Client Information

Name of decedent:	Client Record No:	Unit/Ward (if applicable):	
	Medicare/Medicaid No:	Date of Birth:	Age:
Admitting diagnoses:	Adjudicated incompetent: ☐ Yes ☐ No	Weight (if known):	Race:
	Date(s) of last two (2) medical exams (if known):	Height (if known):	Sex:

Date of most recent admission to a State operated psychiatric, developmental disability or substance abuse facility (if known):	Date of most recent admission to an acute care hospital for physical illness (if known):
Primary/secondary mental illness, developmental disability, or substance abuse diagnosis:	Primary/secondary physical illness/conditions diagnosed prior to death:

Section 3: Circumstances of Death

Place where decedent died:	Date and time death was discovered:	
Address:	Physical location decedent was found:	
	Cause of death (if known):	
Was decedent "restrained" at the time of death or within 7 days of death? ☐ Yes ☐ No If "yes," describe type and usage:	Was decedent in "seclusion" at the time of death or within 7 days of death? ☐ Yes ☐ No If "yes," describe:	
Describe events surrounding the death:		

Section 4: Other Information

Please list other authorities (such as law enforcement or the County Department of Social Services) that have been notified, have investigated or are in the process of investigating the death or events related to the death: